From:	Randy Zickgraf
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	Comments on redesigned Form 990
Date:	Friday, September 14, 2007 4:04:35 PM
Attachments:	Form 990 Redesign Comments 9-14-07 GHS.pdf

To whom it may concern:

Please find attached our comments with respect to the redesigned Form 990.

Thanks you for the opportunity to comment.

Sincerely,

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Randal B. Zickgraf, Esq., CPA
Director

GEISINGER
HEALTH SYSTEM

September 14, 2007

Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, D.C. 20224

RE: Comments on Redesign of Form 990

To Whom It May Concern:

Geisinger Health System ("Geisinger")[1] appreciates the opportunity to comment on the IRS's Form 990 draft redesign. While we applaud your efforts in developing a new Form 990, which has not been revised since 1979, we have significant concerns about the draft redesign. These concerns include components of the Proposed Schedule H, the aggressive implementation date and filing deadlines, as well as the additional cost and burden that will result from the proposed expansion of reporting requirements for our hospital.

As a leading health system in a predominately rural area, providing health care in a variety of settings, we are proud of the community benefit activities and programs which we provide as part of our core mission. The Proposed Schedule H should not redefine community benefit in a manner that permits others to determine what programs and services are most appropriate for the communities we serve. In our view, we should be permitted to report the great diversity of community benefits we provide through our various provider organizations within the system.

We believe it essential that the new Form 990 be focused on its primary function: to disclose meaningful information in a readily accessible fashion. The Internal Revenue Service should not use Form 990 to effectively mandate particular governance and operation standards for exempt organizations, particularly where there are legitimate differences of opinion and strategy on how best to accomplish tax-exempt purposes. The new Form 990 will prove most useful if it focuses on disclosure of information that is relevant to the public and to regulators and for which collection and reporting is not unduly burdensome on exempt organizations.

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[1] Throughout this letter the acronym "GHS" or the terms "System," "Geisinger" or "Geisinger Health System" shall refer to the entire Health Care System comprised of the Geisinger Health System Foundation (the "Foundation") as parent and all subsidiary corporate entities comprising the Health Care System.

Based on our initial review, we have four primary concerns that we request the IRS to address:

- The implementation and filing deadline is far too short and should be extended;
- The full value of community benefit is not included in Schedule H and should be;
- The IRS is requesting unnecessary information that is unrelated to charitable exemption; and
- The IRS is requesting compensation and deferred compensation information that is misleading and confusing.

1. The timeframe to implement the necessary reporting changes is far too short and is unreasonable

It is important to recognize that the new Proposed Schedule H and other newer expanded disclosures will require significant reconfiguration of existing financial and data record-keeping systems for our provider organizations within the system. In particular, these system changes are critical to ensuring that the appropriate data is captured for accurate completion of the new Schedule H, Part I Community Benefit Report.

The aggressive timeline proposed for implementation of the redesigned Form 990 would require that our facilities begin data collection and record-keeping effective January 1, 2008. That timeline is unrealistic, especially given the fact that the IRS does not anticipate finalizing instructions, definitions, and worksheets needed to collect the data until mid-2008. To require organizations to overhaul financial and data recordkeeping systems before the definitions, line instructions and worksheets for making the calculations required for Schedule H are completed is unreasonably costly and disruptive.

It is recommended that implementation of the revised forms become effective for tax years beginning in year 2010 (to be filled in 20011). This would allow the IRS to provide a second draft in 2008 with another comment period ending no earlier than December 31, 2008. That should give organizations sufficient time to revise their financial data and data record-keeping systems in order to track and capture new information that will need to be reported.

2. The full value of community benefit is not recognized in the proposed Schedule H

As currently proposed, Schedule H, Part I Community Benefit Report does not recognize the full value of community benefits provided by tax-exempt health care providers. The community benefit standard permits organizations to tailor their programs and services to the needs of the communities they serve. Among the more pressing needs throughout the predominately rural communities served by Geisinger, is the need for access to quality health care for the underserved, elderly Medicare patients and low-income patients who may not be able to afford the costs of their care.

Medicare underpayments are community benefit. In the proposed draft, Part I allows organizations to report and receive community benefit credit for Medicaid and other government program underpayments, but there is no line item for Medicare cost underpayments. We believe that Medicare cost underpayments should also be included and expressly identified as community benefit.

Serving Medicare patients has been part of the IRS's community benefit standard since 1969 and excluding Medicare underpayments from the tabulation of community benefit costs is inconsistent with this guidance. Medicare, like Medicaid, does not pay the full cost of patient care. As a result, our health care facilities and communities must absorb and compensate for these underpayments. Currently, Medicare reimburses hospitals 92 cents for every dollar spent on care. The Medicare Payment Advisory Commission (MedPAC) in its March 2007 report to Congress cautioned that the situation will get even worse, with margins reaching a 10-year low at *negative* 5.4 percent. Moreover, an increasing number of Medicare beneficiaries are also low-income. More than 46 percent of Medicare spending is for beneficiaries whose income is below 200 percent of the federal poverty level.

Medicare underpayments represent a real cost of serving members of our community and should be counted as community benefit.

The cost of bad debt should be recognized as community benefit. In addition, the proposed Schedule H does not recognize the cost of patient care bad debt expense as a community benefit. In concert with our charitable mission, all the provider organizations within Geisinger have implemented policies and programs to establish eligibility for financial assistance or charity care and take appropriate steps to advise patients of their financial obligations and the availability of financial aid or charity care.

A 2006 Congressional Budget Office report cited two studies indicating that "the great majority of bad debt was attributable to patients with incomes below 200 percent of the federal poverty level." The fact is that despite our best efforts, many patients still do not identify themselves as in need of financial assistance. It is important to us and to our community that the full cost of serving our community – including the cost of serving patients who need help paying their bill but fail to ask for it – be recognized and counted as community benefit. These patients need care and Geisinger fulfills its mission by providing that care.

System reporting option. In large integrated health care systems such as Geisinger, separate corporate entities, both non-profit and for-profit, have been created over time in response to various state and federal regulatory requirements specific to their operations. Typically, there is a common parent that the subsidiary corporate entities are accountable to and, in effect, it is the collection of the entities that carry out the charitable mission of the system. It is possible that because of the interrelationships among the affiliates within a system, one subsidiary of the parent may report little community service, while a related subsidiary may be able to report significant community service. To allow for the greatest possible transparency, we endorse the IRS instruction that organizations with multiple facilities aggregate community benefit information and recommend that the IRS permit health systems with multi-corporate entity providers (as distinct from one organization having multiple facilities) to report community benefit in the aggregate as well.

Pennsylvania charitable exemption requirements. Please note that in Pennsylvania, our state's Institutions of Purely Public Charity Act recognizes that community benefit includes charity care and financial aid, under-funding by government payers (Medicare and Medicaid), and bad debt at cost. To satisfy the state's filing requirements, it is necessary to provide a copy of the Form 990 in order to support continued state charitable exemption.

Changes at the federal level to the definitions of charity care will be confusing to the public as providers seek to demonstrate accountability of service to communities.

3. Unnecessary expansion of reporting requirements

The Proposed Schedule H includes many components that are either not related to organizations meeting their community benefit obligation, or are related to information already provided in other parts of the Form 990. For instance, information related to the organization's revenues and Medicare and Medicaid payments is also already included in Part IV of the core section off the Form 990.

Additionally, the proposed payer mix chart on Schedule H, Part II (Section A, Billing Information) has no impact on being able to determine whether the community benefit standard has been met. As currently constructed this chart will be misleading to the public and will impose a significant burden with respect to the amount of information and the required personnel resources that will be needed to complete the schedule.

4. Misleading information is being requested with respect to compensation and deferred compensation.

Part I, question 8 requests information necessary to calculate the percent of compensation of officers, directors, key employees, etc. to total program expenses (line 17). Also, Part II, Section A, asks for the compensation of officers and key employees. In an integrated system such as Geisinger, where the executives responsible for managing operations that cross multiple corporate entities within the system are employed by a single supporting service organization, the answers to these questions will lead to confusing and misleading results on most of the individual returns of the Geisinger organizations. It is requested that the IRS allow for a group filing of returns for the exempt organizations within a health system. Alternatively, the IRS should allow the opportunity and space for the reporting organization to provide an explanation.

Part II of the core portion of the Form 990 requests information on former officers, directors, key employees, etc. (See Section A, Line 1a and Section B, line 6.) It would be helpful if the IRS would specifically define the look-back period to be consistent with 5-year look-back mandated in Section 4958.

With respect to Schedule J, Supplemental Compensation Information, there are two general areas of concern. First, there is concern about the proposed reporting requirements of deferred compensation. The redesigned Form 990 eliminates the requirement to report qualified deferred compensation as a separate line item. In our view, reporting both qualified and non-qualified deferred compensation would be more transparent and provide the most meaningful information for purposes of comparability. The IRS also requires employers to report deferred compensation multiple times - when accrued, when vested and when paid out. This is confusing and misleads readers of the Form 990. Accordingly, it is requested that the IRS request the information at one time, either at time of accrual or vesting. Alternatively, providing space to explain the issue would be helpful.

In addition, the combination of compensation elements with non-taxable fringe benefits and business expense reimbursements into one "compensation" total as proposed in Schedule J will most likely lead to significant confusion. Inclusion of legitimate business expenses and non-taxable fringe benefits in "compensation" total is misleading. In the event the IRS believes reporting non-taxable fringe benefits and business expenses remains necessary, such information should be clearly segregated from elements of compensation.

It is also requested that Part V, question 6 be eliminated. This question requests the reporting of compensation to disqualified persons not already reported as current officers, directors and key employees. Requesting and accumulating this information will be excessively burdensome and intrusive and will not likely result in meaningful, comparable information. The current IRS definitions and guidance on identifying a disqualified person is subjective in nature and will allow organizations, depending upon how conservatively or liberally they apply the guidance, to report widely varying results.

Conclusion

It is anticipated that the burden of completing the revised Form 990 will increase significantly. We have estimated that the time and resources necessary to comply with the additional data reporting requirements will increase by at least 50% within the system.

An unintended consequence of directing resources to administrative compliance activities will be the reduction of resources available to carry out our core mission of caring for those in our community. We do not believe that was the intent of this effort and the result is inconsistent with the IRS' stated goal for the Form 990 redesign to minimize the burden on the filing organization.

We appreciate the opportunity to comment on the redesigned Form 990 and related schedules, and thank you in advance for consideration of our comments and recommendations.

Sincerely,

Randal B. Zickgraf, Esq., CPA

From:	Carol Pryor
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	Comments of Form 990 redesign
Date:	Friday, September 14, 2007 3:59:13 PM
Attachments:	IRS Comments on Schedule H.doc

To Whom It May Concern:

The Access Project is a national healthcare access research and advocacy organization. Attached are comments we are submitting on the IRS' proposed redesign of Form 990.

Sincerely,

Carol Pryor

Carol Pryor
Senior Policy Analyst
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September 14, 2007

VIA Electronic Mail

Mr. Ronald J. Schultz
Senior Technical Advisor
Tax Exempt and Government Entities Division
Internal Revenue Service
1111 Constitution Avenue, NW
Washington DC 20224

Re: Comments on Proposed Redesign of Form 990 Schedule H

Dear Mr. Schultz:

Thank you for the opportunity to provide comments on the proposed redesign of Form 990 Schedule H.

The Access Project is a national healthcare access research and advocacy organization. We have worked on the issue of medical debt for the last six years. We have published numerous reports on this topic,[1] and also work with community organizations around the country who are trying to mitigate this problem.[2] In addition, we counsel patients with unaffordable medical bills, helping them negotiate discounts and reasonable payment plans with providers. We thus have considerable experience working with people who have received care at tax-exempt, nonprofit hospitals.

[1] The most recent Access Project reports are W. Lottero et al, *2007 Health Insurance Survey of Farm and Ranch Operators*, September 2007; M. Rukavina et al, *Not Making the Grade: Lessons Learned from the Massachusetts Student Health Insurance Mandate*, May 2007; and C. Pryor et al, *Illusion of Coverage: How Health Insurance Fails People When They Get Sick*, 2007. A complete list of our publications on medical debt can be found on our website, www.accessproject.org.

[2] A partial list of our national and local partners can be found in the Funding and Partners section of our website.

Both from our direct service work and from our research and that of others,[3] we know that hospitals vary greatly in their charity care policies and practices. While some hospitals are forthcoming with financial support, at many hospitals patients are not informed about the availability of financial assistance. For those left with unaffordable bills, the result is often delayed care and financial hardship, as well as long term financial problems resulting from damaged credit scores.[4] The American Hospital Association's publication of voluntary charity care guidelines,[5] while helpful, has not been sufficient to ensure that all nonprofit hospitals conform to their charitable missions with respect to patients who lack the financial resources to pay for care. We strongly support the revision of Form 990 Schedule H because it will provide more accurate, detailed, and consistent information on the actual charitable contributions of tax-exempt nonprofit hospitals.

We would like to make a few comments about the proposed changes.

Quantifying Charity Care and Reporting Bad Debt

One important benefit from the redesigned Schedule H is the requirement that hospitals quantify the amount actually spent on charity care, with that amount calculated at cost rather than charges. As your Interim Hospital Compliance Report indicates, hospitals vary greatly both in their definitions of and the percentage of revenues spent on community benefits and uncompensated care. While hospitals frequently claim large expenditures for uncompensated care, in some cases these amounts reflect charges rather than costs. Since charges are often greatly inflated above actual costs,[6] this produces a highly misleading figure of the amount of uncompensated care provided.

In addition, we believe that it is crucial that bad debt be differentiated from community benefits. From a patient's perspective, bad debt can hardly be considered charity care. For many patients it results in long term damage to their credit records, making it difficult for them to access needed credit, for example to buy homes or cars, and leaving them vulnerable to predatory lenders offering sub-prime loans.[7] Excluding bad debt from charity care is also consistent with the Healthcare Financial Management Association's recommendations for recording bad debt and charity care.[8]

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[3] See for example J. Flory, *A Tear in the Safety Net: Hospitals Fail to Ensure Financial Assistance for Low-Income Californians*, Health Consumer Alliance, Fall 2006, and *Hospital Free Care: Can New Yorkers Access Hospital Services Paid for by Our Tax Dollars?* Public Policy and Education Fund of New York, September 2003.
[4] C. Zeldin et al, *Borrowing to Stay Healthy: How Credit Card Debt is Related to Medical Expenses*, Demos and The Access Project, 2007 and R. Seifert, *Home Sick: How Medical Debt Undermines Housing Security*, The Access Project, November 2005.
[5] *Hospital Billing and Collection Practices: Statement of Principles and Guidelines by the Board of Trustees of the American Hospital Association*, December 2003.
[6] G. Anderson, "From 'Soak the Rich' to 'Soak the Poor': Recent Trends in Hospital Pricing," *Health Affairs*, May/June 2007.
[7] Seifert, *Home Sick*, 2005, and Zeldin, *Borrowing to Stay Healthy*, 2007.
[8] *Principles and Practices Board Statement 15: Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers*, Healthcare Financial Management Association, December 5, 2006.

Allowing bad debt to be considered as charity care also reduces hospitals' incentives to proactively inform people about charity care programs and assist them in completing the application process. In its August 21, 2007 letter to the Internal Revenue Service, the American Hospital Association (AHA) objects to excluding bad debt when calculating community benefits. The letter states "A significant majority of bad debt is attributable to low-income patients, who, for many reasons, declined to complete the forms required to establish eligibility for hospitals' charity care or financial assistance programs."

Our experience working with numerous low income patients who have incurred bad debt may be instructive. Many of these patients were never informed of the existence of charity care programs, so were unable to even attempt to complete applications. Others have described confusing or complicated application processes or onerous documentation requirements that made completing applications nearly impossible. In addition, we have spoken with hospital officials who claim "non-compliance" rates of more than 80 percent for their charity care application processes. Levels this high raise concerns about whether the application process or documentation requirements are too difficult for most patients to comply with. If hospitals are allowed to include bad debt as a community benefit, they will be less motivated to ensure that eligible patients learn about financial assistance programs and assist them in meeting the application requirements.

The instructions the IRS provides for completing line 6b on the redesigned Schedule H, which refers to hospitals' debt collection policies, require hospitals to "state whether amounts that are designated as charity care may be subject to collection procedures or referred for collection to a third party either before or after charity care determination is made." For the reasons outlined above, we recommend that amounts subject to collection procedures or referred for collection should *never* be recognized as charity care. Bad debts, and the problems they cause for patients, are anything but charitable.

Reporting on Charity Care Policies

An additional benefit of the revised Schedule H is that it requires hospitals to describe their specific charity care policies, including eligibility requirements (line 13b of the revised schedule). In spite of the AHA guidelines directing hospitals to share their charity care policies freely with the public, our experience is that many hospitals do not follow this recommendation.[9] As discussed above, some hospitals fail to proactively inform patients about the existence of charity care programs. Others claim to have policies but refuse to provide detailed descriptions of them; we have been told by more than one hospital official that if they released the details of their charity care policies, patients would lie in order to become eligible.

Real monitoring of hospitals' behavior regarding charity care often falls to local advocacy groups concerned with protecting vulnerable patients from devastating

[9] W. Lottero and C. Pryor, *Voluntary Commitments: Have Hospitals That Signed a Confirmation of Commitment to the American Hospital Association's Billing and Collections Guidelines Really Changed Their Ways?*" The Access Project, May 2005.

financial losses. The information included in Schedule H will make it easier for them to ascertain whether hospitals are in fact complying with their own stated charity care policies.

In this regard, we suggest that it would be useful to require hospitals to include a link to an online copy of their charity care policy *in its entirety* rather than merely providing a summary version. We also suggest that hospitals report on how they have disseminated the policies to patients and members of their communities.

Adjusting for Offsetting Revenue

While hospitals have made various claims about the amounts of uncompensated care they contribute, they do not always adjust totals to reflect amounts received from other sources to cover the costs of uncompensated care. These funds may be received, for example, from private donations, state funds, or federal Disproportionate Share Hospital funds. We thus support the inclusion in the revised Schedule H of a column (column d, part I) in which hospitals report revenue that offsets their charity care expenditures.

Instructions for completing this item state, "'Direct offsetting revenue'" means revenues from the activity received during the year that offset the total community benefit expense of that activity." The instructions should clarify that this includes all revenues received from all sources to offset the cost of uncompensated care.

Reporting on Billing and Collections

The AHA, in its comments on Schedule H, states that the chart on Billing and Collections (Part II, Section A) should be eliminated because it has no relationship to community benefits. We believe the information provided in this chart should be retained. It provides important information on charges and discounts provided to uninsured patients compared to those of other payers. Overcharging of uninsured patients has been a topic of great concern in the past few years – it has resulted in lawsuits, state legislation, and Congressional hearings. Since most uninsured people are lower income, overcharging may have particularly deleterious effects on those with fewer resources to pay for care.[10] Information in the chart will thus provide needed insight into the degree to which hospitals are expecting the uninsured to pay prices significantly higher than patients with insurance.

Along with overcharging, many hospitals have used aggressive collection measures to try to gain payment. These have included liens and foreclosures on homes, garnishment of wages, and on occasion even arrest. For this reason, the inclusion of questions 6a and b in Section B in Part II, which ask hospitals if they have written debt collection policies and, if so, to describe their charity care policies, is important information. The instructions for completing line 6b state, "If the organization uses collection procedures or refers collections to third parties, describe when such procedures are used or when such referrals take place." We suggest these instructions be expanded to include

[10] G. Anderson, "From 'Soak the Rich' to 'Soak the Poor'," 2007.

information on when hospitals seek legal judgments against people and when they sell receivables to third parties. In addition, it would be useful to require hospitals to provide a link to an online copy of their complete debt collection policy.

Filing by Hospital System Rather Than by Hospital

The instructions for completing Schedule H state that organizations that include multiple medical facilities need only provide information for the aggregate system rather than for each individual hospital. We believe that it is important for communities to have access to the charity care policies and contributions of their local hospitals, which may be difficult if hospital systems need to complete only one Schedule H with aggregated information. Therefore, we recommend that hospitals systems submit a Schedule H form for each hospital in their system.

Date of Implementation

The AHA recommends that hospitals not be required to complete the revised Schedule H form until 2010. We see no reason for delaying implementation until that time. Hospitals have been aware of issues surrounding their provision of charity care for several years. The AHA released its guidelines on hospital billing and collections practices in December of 2003, almost four years ago, and hospital leaders testified before Congress on these issues in June of 2004. The AHA guidelines recommended that all hospitals have written debt collection and charity care policies and that they should make charity care policies available to the public. Hospitals have thus had several years to standardize their information and make it available. Requiring hospitals to file revised Schedule H forms during 2009 simply codifies behavior that the AHA has recommended to its members.

In conclusion, we would like to again express our support for this important initiative by the Internal Revenue Service to define and standardize reporting requirements for tax-exempt hospitals' community benefit obligations. This information will be of great value not only to professionals concerned with these matters, but to local communities and the public at large.

Sincerely,

Mark Rukavina
Executive Director
The Access Project

Carol Pryor
Senior Policy Analyst
The Access Project

From:	bob.okeefe@aurora.org
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	Proposed Amendments
Date:	Friday, September 14, 2007 3:51:50 PM
Attachments:	irs 990 comments.pdf

To the IRS:

Attached please find Aurora Health Care's comments on the proposed amendments to Form 990.

Robert O'Keefe
Vice President, Treasury Services
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Aurora Health Care

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September 14, 2007

To the Internal Revenue Service:

I am writing on behalf of Aurora Health Care, Inc., a not-for-profit integrated delivery network based in Milwaukee, Wisconsin. Aurora serves 100 communities in the eastern 1/3 of the State of Wisconsin through 13 hospitals, a physician practice that will soon comprise in excess of 1100 physicians, 130 pharmacies, Wisconsin's largest home health organization, and various other health care and social service providers. Aurora is one of Wisconsin's largest employers with in excess of 26,000 employees.

Aurora acknowledges that there is an appropriate level of public accountability and transparency that goes hand-in-hand with one's position as a not-for-profit organization. We recognize that it is in that spirit that the Internal Revenue Service proposes to amend the Form 990, and we are generally comfortable with the proposed changes.

However, we believe that certain components of the proposed **Schedule H** should either be delayed or eliminated, for the reasons given below:

1. As expressed by numerous other respondents, we believe it would be more reasonable to implement Schedule H after the IRS has issued its final instructions and has given reporting entities an opportunity to modify their underlying systems to facilitate electronic data gathering. For large and diverse organizations such as integrated delivery networks, it will be no small effort to produce the requested information. Hence we suggest the implementation date be deferred to no earlier than fiscal years beginning after January 1, 2009.
2. We believe it is unreasonable to require public reporting of the information proposed in Section II. It has no relevance on whether an organization has met its community benefit responsibilities. Also, while information about contracts with individual insurance payors would not be apparent from the reported data, there could be an "order of magnitude" inference about discounting levels that is competitive and proprietary in nature.
3. Questions 1 and 3 of Part IV are unduly vague, broad and burdensome. The underlying issues addressed in those questions are highly complex, and do not lend themselves to brief answers.

We appreciate the opportunity to offer our comments.

Sincerely,

Robert O'Keefe
Vice President, Treasury Services
Aurora Health Care, Inc.

From:	Wallace, Gene
To:	*TE/GE-EO-F990-Revision;
CC:	
Subject:	Comments on Draft to Proposed Changes to Form 990
Date:	Friday, September 14, 2007 3:48:35 PM
Attachments:	Comments to Proposed Changes IRS.pdf

Please see attached letter with my comments on Draft to Proposed Changes to Form 990.

Sincerely,

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Atrius Health

September 14, 2007

Internal Revenue Service
Form 990 Redesign, SE:T:EO
1111 Constitution Avenue, NW
Washington, DC 20224

Submitted via email to: Form990Revision@irs.gov

Re: Comments on Draft to Proposed Changes to Form 990

I am the CFO of Atrius Health, a group of five tax exempt (501(c)(3)), physician group practices that employ over 600 physicians and has total revenues of just over $1.0 billion dollars. We operate as one large multi-specialty group practice. Although we have many concerns with the proposed form, we will confine our comments to the areas with the most significant impact to us as follows:

Part II, Section A, column (d) and (e)
What is reportable compensation should be modified
To assure that compensation is comparable between reporting entities, we would be concerned that a major component of compensation, deferred compensation, is excluded from this section. The current Form 990 has categories for Compensation, Contributions to employee benefit plans & deferred compensation plans and Expense account and other allowances. These categories are inclusive enough that, even with differences of interpretation of how to categorize, in the end 100% of compensation is reported. The redesigned Form 990 will require filers to provide less information than the current Form 990.

Schedule J- Supplemental Compensation Information
What is reportable compensation should be modified
Again, to assure that compensation is comparable between reporting entities we would recommend that deferred compensation be included in this section of the Form 990. Also, in addition to the confusion that will likely result from combining compensation elements with non-taxable fringe benefits (including deminimis fringes) and non-taxable expense reimbursements (including those from an accountable plan), we feel our organization will have significant burden and cost in the accurate tracking of this level of detail.

Schedule H- Hospitals

Who must file should be clarified

As drafted, all organizations that respond "yes" to Part VII, question 9 "Did the organization operate, or maintain a facility to provide hospital or medical care?" must complete Schedule H. The question is very broad and on the surface would seem to require our organization, a physician group, to complete the schedule.

As you look into the details and instructions of Schedule H, there is heavy "hospital" emphasis, which we have never considered ourselves to be. In fact, we perceive a hospital as a health care organization with inpatient facilities providing medical, nursing, and related services for ill and injured patients 24 hours per day, seven days per week.

Further, the IRS "Rationale" for Schedule H discuses: 1) the need to "quantify the community benefit standard applicable to tax-exempt hospitals" and 2) "community benefit reporting" as if it were something we currently do.

Consequently, we need clearer definition as to, whether or not, it is intended for an organization such as ours to complete this schedule.

Schedule H should be delayed

Depending on the outcome of whom must file, per above, our organization would be heavily burdened with reconfiguring financial and data record-keeping systems to capture, by January 1, 2008, the substantial amount of information required just for Schedule H. In addition, if the final version of the reporting requirements were to be published after January 1, 2008 it may be problematic to have the reporting effective retroactively to January 1, 2008.

Conclusion

We appreciate the opportunity to submit our comments. While we agree that exempt organizations must continue to be transparent and accountable, we would caution against reporting requirements that are burdensome, cost prohibitive to fulfill or fall short of accomplishing comparability of organizations.

Sincerely,

Eugene C. Wallace
Chief Financial Officer